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THE DIAGNOSIS AND THE SURGICAL TREATMENT OF HEMORRHOIDS, INTERNAL, EXTERNAL, INFLAMED OR ULCERATING, BY FULL, BUT GRADUAL ANAL-DILATATION; BY LOCAL ANALGESIA, COMBINED WITH PRESSURE-MASSAGE; ALSO A FEW NOTES ON HEMORRHAGIC HEMORRHOIDS.

BY THOMAS H. MANLEY, M. D.,

[Visiting Surgeon, Harlem Hospital, New York.]

I HAVE already, in different medical periodicals of late years, been permitted to occupy space, in setting forth, in diverse contributions, the structural anatomy and functions of the *intestinum amplum*; or the large pouch-like terminus of the rectum, the greater part of which is lodged in it, immediately contiguously to the ischiatic fossa.

This being the case, I will not occupy time, in the present instance, in considering structure and rectal phenomena, in the ano-rectal district, but, after a few reflections in a general way, proceed at once to diagnosis and treatment.

In the beginning, I may say, that since I commenced to make a critical study of ano-rectal diseases, I have found to my amazement and confusion on making a large number of examinations on the dead and living body, that a hemorrhoidal or varicose state of the vascular part of the lower rectum was present in more than ninety per cent. I discovered by interrogating the living, that of those in whom pathological changes of a hemorrhoidal order was present, not more than *ten per cent.* ever were aware that they had piles at all. We must then infer that something more than the mere presence of a few scattering tabs of tissue around the anal margin or small neoplasmata within, should co-exist, to bring into play that most agonizing disorder, designated hemorrhoids; a condition, which of all others, can make one's life wretched and miserable. And when intermittent paroxysms of furious itching, pain and straining come on, particularly when one "turns in" for a night's rest, the distress and torture which they often excite are something dreadful.

We will, in this issue of the TIMES AND REGISTER, discuss the subject from a medical standpoint, and illustrate the share a disordered system contributes in the etiology, but what I wish to particularly emphasize is, that if we would strike at the root of the malady, we must address our attention to something besides the deeply congested varicosities which line the walls of the bowel, and endeavor to institute a line of treatment which will not involve a mutilation and loss of blood, or perhaps lay the foundation for subsequent dangerous consecutive hemorrhage, ulcer, or fistula, and something which will not inflict great shock to the system, but will be permanent in its results.

I may say here, that the measures which will be recommended are only for those chronic, intractable hemorrhoids, which simple, constitutional and local measures will not control, which are of a chronic character and rebellious to local treatment.

DIAGNOSIS.

Let us be sure that "we have caught the hare before we light the fire to cook him."

How many poor creatures there are with an itching, irritable, painful rectum, with their anal excavation plastered over with various "pile ointments," partaking freely of bilious medicines, who are as innocent of hemorrhoids as the unborn babe? Any trouble in the rectum is almost invariably set down as "piles."

Here are a few illustrations. Patient sent to me by a practitioner for unmanageable piles. I examine his rectum and find an immense, punched-out tuberculous ulcer.

A young woman comes to me with "ulcerating piles." The salves do her no good. Her rectum is full of ulcerating and sloughing condylomata. Papa —her husband—had been cured of his piles (?)

A physician comes to me from the country with his patient, who had terrible bleeding piles, which terribly exsanguinated her. On examination high up, I find two or three angiomatous polypi.

A young physician brings his father to me to examine his rectum, as he has been latterly under treatment for piles. He has a rectum as hard as a horn, which, at the sphincteric orifice, is one mass of cancerous deposit.

Many come to be treated for hemorrhoids, who have fissure, ulcer or stricture of the rectum.

Hence, from the foregoing, it is clearly evident, that before we think for a moment of healing chronic piles, we must assure ourselves that our patient really has the genuine article.

Now, in reaching a diagnosis of hemorrhoids, we must depend mainly on the faculties; the hearing, touch and sight.

In the large majority of cases, a skillfully conducted oral examination, along with the cautious, but searching glance of the eye, will aid enormously, as a preliminary. You will see the hectic of phthisis, the tinged anæmic skin of cancer, and if the patient has, so-to-speak, "held on to his hair," in syphilis, by putting this and that together, you will draw out enough to give you good reason to suspect it. By this sort of an examination, too, one will lead the patient on, until you secure his full confidence, as you may anticipate him in many details.

In simple, chronic hemorrhoids, there will seldom be much difficulty in reaching definite conclusions as to their presence, before we touch them.

EXAMINATION OF THE RECTUM.—Two things are quite indispensable for a rectal examination. They are first, touch; and second, good light—the use of vision.

Now the first is the most valuable in a general way, because with many sensitive, modest women, a visual examination often is refused; is only very reluctantly consented to, so that if you can not only make an examination, but also treat her affection under her clothing, and cure her, you will, for her lifetime, have the fullest measure of her gratitude.

Thoroughly scientific examination of hemorrhoids is not always possible, without a full exposure of the closed or opened anal portal. It is almost unnecessary to say that in malignant diseases or polypi, the sense of touch is quite enough as a local diagnostic resource.

TECHNIQUE OF RECTAL EXAMINATION.—When a thorough and complete examination is imperative, as in cases of ulcerating or bleeding hemorrhoids, the patient should be placed on a table from three to four feet high; if a male in the dorsal decubitus; and, if a female, on the left side. And I may say here in parenthesis, that chronic pathological changes in the rectum are comparatively very rare, except in proportion in middle-aged or old people. We must have good light. Now, it must not be inferred, when good light is mentioned, that a voluminous glare is needed. On the contrary, what we need is not brilliancy, but a *contrast light*. If we have clear sunlight, it is simple; but if on the contrary the day is gloomy, or an examination is made in the darkness of night, a simple tallow-dip, a luminous candle, or two; both lit at once, the light reflected with a common hand-mirror into the rectum, or on the cutaneous margin of the anus will answer.

However, before we proceed to inspection, we should first make a digital examination. I would recommend the amateur to first familiarize the touch, and acquire the *tactus-eruditus* by examining the recta of the healthy in every possible instance, when a pretext presents itself.

The patient being now resting com-

fortably, and not unduly exposed, it is well, always to assure him or her that there will not be much pain inflicted, and that he must not resist us. The anal sphincter is always closed by a tight grip, in hemorrhoidal disease, and acts not altogether unlike a stricture in the dry urethra, in the first passage of instruments. We must then commence manipulations on the sphincter-ani by a species of coaxing, "catch it off its guard," and then thoroughly subdue it.

To commence with, I generally sponge the part freely with warm water, after which, with my index finger well-warmed and oiled, the pulp is brought slowly up against the anal folds. At first the corrugations of the sphincter plaits are drawn tighter than ever, but the finger is kept there, and gentle, but steady pressure is begun against it, when we are soon conscious of a giving way as the tip enters. Now that we are within the anal cul-de-sac, into the rectum, we give our patient a little rest, and we need a little ourselves, for if we would succeed with these cases, without torturing our patient, we commence cautiously and slowly, so that after the sphincter is passed, we are often not a little fatigued. At any rate the hand is tired. I have spent twenty minutes more than once in making my finger pass the sphincter. The tip of the finger is now kept in the rectum, without advancing farther, for at least five minutes. In the meantime, its point being slightly worked while there, by the weight of the hand, quiet but steady tension is made in the direction of the long axis of the longitudinal fibres of the sphincter-ani.

A little fresh oil is now dropped on the engaged finger—the part exposed—and it is sent into the webbing. A "to and fro" motion now is given this finger before another is introduced. It is lifted up in the direction of the bladder, turned towards the sacrum, and the ischial tubers, partly withdrawn and again re-introduced.

After this manipulation, we commence the passage of the index of the left hand, following on the same lines as the first. Then the middle finger of each hand, if necessary, though very often but the two indices are required.

By this procedure, when proper precautions are observed, the anus is amply dilated to permit a thorough inspection. The loss, temporarily, of sphincteric contractile power, is manifested by the free escape of feces.

We commence our ocular examination at the verge of the anus.

Questions to be Answered.

1. Has our patient piles? If so, of what type?

2. Are they simple or complicated with fissure, ulcers, abscess of fistula?

3. Has the patient an entire absence of hemorrhoids, and is he rather suffering from a neoplastic infectious malady, as cancer, syphilis, or tubercle, and if malignant, where is its precise seat?

It might be said that it was rather premature to put questions before we have employed the speculum and other mechanical means, as an aid to exploration.

Under ordinary circumstances the less instrumentature in anal examinations the better. Many times the brethren have written me "whose special anal speculum do you recommend?" My answer is that the best is "none at all," in uncomplicated cases. With the sphincter amply dilated—and no speculum should ever be employed until this has been secured, as a preliminary measure; the rectum rolls out, prolapses, and we have under our eyes the entire field of pathological changes

In those in whom the anus is well stretched, if any sort of speculum is useful, nothing in my hands serves more admirably than a Simon's vaginal, well-warmed and oiled, and very gently introduced. The blade of this instrument being about four inches in length—about one-half the length of the entire rectum, and all that part of the tube which is uncovered by peritoneum—we have at our command a clear sweep of the whole field. With a tampon placed high up, the mucous membrane well drenched and this speculum raised, depressed, or turned anteriorly first, posteriorly second, to the right third, and the left side lastly, a thoroughly complete inspection is always a simple procedure in appropriate cases. Certainly in those whose lower passage is the seat of stricture or malignant disease, this instrument must not be em-

ployed. Indeed, in this class of cases an ocular inspection is quite unnecessary.

HAS OUR PATIENT HEMORRHOIDS, AND IF SO, OF WHAT DESCRIPTION?—Time will not permit the consideration of the diverse variety of piles. In a physical examination, you cannot confound hemorrhoids with other affections. In a young or middle-aged man, or woman, with no pronounced cachexia, before we examine, we may quite assure ourselves of their presence.

ARE THE HEMORRHOIDS COMPLICATED WITH ULCER, FISSURE OR FISTULA?—Hemorrhoids provide the ground-work of the greater part of the cases of ulcers and fissures. So-called fistula in ano is almost invariably consecutive to hemorrhoids. It is mis-named "fistula-in-ano" for the reason that, in the greater part of these cases, the fistula externally appears at some distance from the anal verge, and, internally, starts at a point some distance above the outlet. In fact, they clear the anus altogether, and nowhere in their sinuous path touch it, except in few cases.

With chronic hemorrhoids, then, we must always look for those lesions so ominously consecutive to them. My own observations, in a considerable number of cases, incline one to regard hemorrhoids as an exciting factor in the etiology of epithelioma in elderly people.

IS OUR PATIENT SUFFERING RATHER FROM GONORRHŒAL INFECTION THROUGH RECTAL COITUS, TUBERCULAR ULCERATION, SYPHILITIC HYPERPLASIA, OR A NEW GROWTH OF SARCOMATOUS OR CANCEROUS ORIGIN?—Many an unfortunate has been turned away with a few purgative pills, a pile ointment, or lotion, by the attending practitioner, who never had hemorrhoids in his life, and a mere placebo given for such serious pathological conditions, which, if treated early and energetically, may be arrested at the start; but which when once the work of diffusion and infiltration into the loose cellular tissues, the perineum, the prostate or bladder, the vagina or uterus in the female has begun, we are often limited in our practice to palliative measures, as radical resources are now quite out of the question.

Gonorrhœal-proctitis is often met with in our larger cities. Its onset is sudden, and it is rapid in its destructive consequences. The agonizing straining it occasions is something harrowing. It may advance upward and involve the peritoneum. It may be easily diagnosed by the quality of the discharge and the virulence of the inflammatory changes. Cancer and syphilis, when present in the rectum, in their early stages, are not so easy to determine. We must depend largely on the clinical history, with reference to heredity; pre-existing lesions, etc. If one be in much perplexity, he should give the patient the benefit of the doubt, and put him through a thorough and extended mercurial course. If cancer be diagnosed, however, it is well to always determine, with as much certainty as possible, its precise location and extent, for when it begins near the anal verge, it may be readily and safely extirpated, while, on the contrary, if it be lodged in the rectal walls a finger's length beyond the anus, the case is beyond the reach of art to more than relieve, when we must give a prognosis accordingly.

Tubercular ulceration of the rectum is a much more common malady than is generally supposed.

It manifests itself by almost intolerable itching, nocturnal, tenesmic straining; and a copious emission from the rectum of a muco-purulent discharge. Many of the symptoms common to hemorrhoids attend this malady, so that, unless a special and very careful examination of the rectum be made, one is liable to overlook its real character, and employ temporizing remedies, when, by the use of proper measures, its course may be cut short in almost every case in which there is not an infection of important organs.

THE VARIOUS SURGICAL OPERATIONS FOR THE RADICAL AND PERMANENT CURE OF HEMORRHOIDS.—Having determined the probable presence of piles by such subjective symptoms as leave little doubt as to their true character, or, after verifying, by an ocular inspection, their actual presence, our next concern is to cure them. But let it be clearly understood here, that only in those severe, chronic, refractory cases, should operative measures be advised or practiced; for, of all regions of the body, the ano-rectal is one of the most dangerous for surgical interference, unless special precautions are always observed.

The nerve supply to the rectum is from the pubic and fourth sacral. The sphincter and levator-ani are animated from the same source. The terminal filaments of these freely inosculate with small sciatic, sacral plexus and great sciatic; the anus is chiefly supplied from the sympathetic. Hence, with its abundant nerve supply, we can readily understand why so frequently in operations in this situation, shock is altogether out of proportion to the extent of mutilation. The immediate operative-mortality in hemorrhoidal operations, at St. Mark's Hospital, London, was but one to 670 operations. Allingham, in 1600 operations, had no deaths.[1] This was much lower than Cripps' or Carding's.

But if the *operative mortality* is low the consecutive pathological lesions and effects on the general system are many in those on whom operations are performed which entail the loss of blood, or mutilation of tissue.

Cripps,[2] in speaking of the consecutive or secondary hemorrhage, says, "There is nothing which so taxes the resources of the surgeon, as in cases of recurrent hemorrhages after operation. The dangers are grave, the patient and friends being powerless in the emergency and are wholly dependent on the surgeon's prompt action."

But supposing the surgeon cannot be found until the escape causes mortal symptoms, or is only controlled when so much has been lost as may forever leave a shattered constitution, the consequences must be disastrous. Hence, those hemorrhoids which admit of a cure without the scalpel, should be treated by such means as will not imperil our patients' lives, or leave the parts favorable to other subsequent lesions.

SURGICAL PROCEDURES COMMONLY EMPLOYED IN NON-HEMORRHAGIC HEMORRHOIDS.—Injection, ligation and excision are the most common means resorted to by surgeons until recently. Not long since Whitehead devised an operation which takes his name. Its complete performance always entails a considerable sacrifice of healthy enteric tissue, a large loss of blood and a tendency, on union, of a subsequent annular rectal stricture. When primary union fails, after the operation, an enormous hiatus in the rectum remains, which only heals after a long lapse of time, by a tedious process of granulation.

If it were not for the dangers of secondary hemorrhage, and impossibility of preventing infection of the wound, the complete and radical excision of the masses would be a most satisfactory operation.

Ligation is not as useful as one might suppose. It is quite impracticable in hemorrhoids high up, as well as in those with broad, sessile bases. When the rectum is the seat of active inflammation, or when degenerative interstitial changes in the walls of the hemorrhoid have occurred we can do nothing with the ligature. The range of the employment of ligatures in hemorrhoids is definitely limited, and when employed in selected cases, many cases have been permanently cured.

It is well to note the phenomena by which the evolution to health is effected. The necrotic gangrenous changes in the hemorrhoid often produce a tendency to consecutive fistula at the root of the sloughing tumor.

Injection, directly into the hemorrhoid, of coagulating or caustic substances is another expedient It is unnecessary to name all the substances which have been employed for this purpose. Suffice it to say that their name is legion. Their *modus operandi* is on the theory of an irritant, mechanical inflammation, with an aseptic shrivelling or resorption and atrophy, which effaces the hemorrhoids. Crystal carbolic acid reduced by heat has met with the most favor; a drop or two injected into each mass. The operation is simple, but we can readily see that except in distinctly pedunculated piles, this phenating of the inner walls with an escharotic will not avail. In those masses composed of mixed vascular, angiomatous elements, it has no place, and is almost certain to cause future trouble, if resorted to. There are many other operative procedures which are, however, with few exceptions, all derivatives of the three above named.

HEMORRHAGIC HEMORRHOIDS, OR BLEEDING INTERNAL PILES.—A con-

[1] Allingham on the Rectum, p. 127.
[2] Cripps, on Diseases of the Anus and Rectum, p. 110.

tribution on hemorrhoids, it is feared, might be regarded as inexcusably defective, if it did not make some reference to *bleeding piles;* hence, before concluding with the subject of treatment of the non-hemorrhagic variety, this phase of the disorder should be glanced over.

Without entering into the subject of the pathology of this phase of the malady under consideration, at the outset we may ask, assuming that a correct diagnosis has been made, is it always judicious to interfere in those cases in which the loss of blood is not of such frequency or quantity as to make its impress on the general health? My impression is that for those who live on rich food, take insufficient exercise, or manifest a propensity for internal inflammation, an occasional spontaneous rectal phlebotomy, is often most salutary in its consequences.

[1]Montague reports a singularly interesting case, cited to him, by Larrogue.

A mademoiselle, a lady of rank, he says, on approaching the age of puberty was pronounced by skilled physicians, hopelesly ill with pulmonary disease. But her menses coming on, all her lung symptoms vanished. At the age of 44 her menopause arriving, pulmonary symptoms again set in, in an aggravated form. Now, she had a copious hemorrhoidal flux, and perfect health was again restored. These bloody fluxes continued from the rectum, from time to time, till she was 66 years old, when they ceased and the lung symptoms now set in with mortal effect.

Bodson of London, in 1832, reported another remarkable case in the *Lancet* for January of that year, which seemed to strongly confirm Montague's views

He was consulted by a young gentleman of 24 years of age, who had been married two years. He was emaciated, stooped and feeble. Examination of the chest revealed clear evidence of incipient pulmonary disease. Thinking that perhaps the young man had indulged excessively in the conjugal relations, he was ordered to sleep in another bed from his spouse. This, however, had no effect. Now, Bodson remembering that he came from a hemorrhoidal family, determined to try the effect of bleeding at the anus.

With this end in view he applied eight leeches at the verge of the young man's rectum, with the most desirable effect. The cough ceased. He commenced to gain in flesh, and was soon wholly restored to health.

But we will meet cases in which the loss of blood is excessive, our patient's health is shattered, and even life threatened. Such a case was sent to me this past summer, by Dr. Acker, of Croton-on-the-Hudson. She was bleached as white as marble, and bled terribly. Such cases must be promptly dealt with.

If the hemorrhage is small, simple astringents may suffice. If it be excessive, ice must be passed into the rectum, or even digital pressure employed, until the immediate bleeding ceases. Radical and permanent treatment embraces *complete* anal dilatation, the rolling out of the rectum, and thorough destruction of the fungous, mossy masses or papillæ, which occasion all the trouble. The actual-cautery, Paquelins or the galvano, is a sovereign remedy for this condition.

COCAINIZATION, DILATATION AND PRESSURE-MASSAGE AS A RADICAL REMEDY.—Except for bleeding hemorrhoids and those complications previously noted, this therapeutical tripod, employed with the minutest attention to detail, has, in my hands, enabled me to dispense with every sort of cutting operation which entail the loss of blood in hemorrhoids of every description.

The *rationale* of the treatment consists in rigorous asepsis, local analgesia with subcutaneous cocainization, dilatation and pressure-massage.

To my mind, it possesses very great advantages:

1st. In avoiding the loss of blood.

2d. In avoiding consecutive inspection.

3d. In not leaving a condition favorable to stricture.

ADVANTAGES TO THE PATIENT.—1st. The operation is less expensive to the poor, as assistants may be dispensed with.

2d. He may continue at his usual occupation the next day after treatment.

3d. The dangers attendant on pulmonary anæsthetics are entirely escaped, when organic disease is present.

[1]Traité des Hemorrhoides, Fluxes, Hemorrhoidaire, etc.

PREPARATION OF PATIENT AND TECHNIQUE OF OPERATION.—The day before operation the bowels should be well cleared by a saline laxative.

Before operation is commenced, the patient may have a substantial meal.

Before the patient is placed on the table for operation, the colon should be well washed out with sterilized water, and the perineum should be shaved and scrubbed. Now, from two to four ounces of whisky or brandy should be given; and we are ready to commence preliminaries.

The index-finger being introduced into the rectum, the subcutaneous and intrasphincteric injection of cocaine solution (1 to 100) is commenced, making but four independent punctures; but, after Reich's plan, spraying the subcutaneous muscular and cellular tissues, in a *radiated* direction, until the entire annular zone of the anus is analgized. This completes the first stage of the operation. Now, a tampon of gauze is introduced, as high up as the vesico-rectal fold of the peritoneum, and a long, thin fringe of cocainized gauze is passed through the anus, as far as the tampon, and allowed to remain for a moment in contact with the nude mucous membrane, when it is withdrawn. Now anal dilatation is completed. This must be thorough, until all resistance to the distending digits is at an end. The rectum is then thoroughly flushed with sterilized water, when we commence the third and last stage of the operation.

We now, with the index and middle finger in the rectum and the thumb resting externally, against the verge, separately seize the hemorrhoids and violently compress them between the finger and thumb. If they are very large and numerous, then, in order to do the work of compression radically, the intestine should be prolapsed slightly, and each caught and separately emptied of their blood: and have the walls well rubbed together, being alternately compressed and twisted on their bases or pedicles, until we are assured of an active, traumatic inflammation immediately setting in. When there is a large cluster on the outside, in order to make analgesia doubly certain, douche them with a syphon of acid carbonated water, or, in want of these, pour a pitcher of iced water from a height slowly on to them. These are seized and twisted in the interval. The rectum is again flushed and the tampon removed, when an opium suppository is introduced. Now, as the sphincteric power is temporarily crippled, there is an escape of fluid feces, unless we adjust a firm, substantial compress, which, while obstructing them, gives great comfort to the hemorrhagic parts.

When pressure-massage has been thoroughly carried out, there is practically nothing more to do. Consecutive inflammation effectually destroys the endothelial lining of the hemorrhoids; their bloody contents, first coagulating, disintegrate and are absorbed in time, leaving, as a residue, a few scattered atrophied stalks to mark the former site of the hemorrhoidal varices.

For the past two years this has been the procedure which I universally employed in hospital and out of it. The number, during the past year, was unusually large, and, as far as we could follow the cases, or trace them, through the physicians who sent them, the results have, in all cases been satisfactory and the cures permanent.

For the village and country practitioner the method is a most valuable acquisition, commending itself equally for its simplicity, efficacy and permanence of cure.

302 W. 53D ST.

AN IMPROVED METHOD AND NEW INSTRUMENT FOR RADICAL CURE OF HEMORRHOIDS WITHOUT OPERATION.

BY E. WYLLYS ANDREWS, A. M., M. D.,
[Prof. Clinical Surgery, Chicago Medical College.]

THE hypodermic method for the radical cure of hemorrhoids is marvelous in its success in some cases, while in other instances it is so painful, disappointing and disagreeable that nearly every operator learns to shun it, however enthusiastically he may have practiced it for a while.

That this method never can be free from risk of sudden death by embolism, is clear from its very nature and mode of action. Similar injection of naevi, and small varices by coagulant injections, was long ago practiced, with a small but regular percentage of sudden deaths, until it was practically abandoned. A well-known surgeon in Chicago had a child die instantaneously, before a large

class of students, after the injection of a small naevus of the face.

This danger can never be eliminated or controlled. Nine cases of death following hypodermic injection of piles have been collected by the writer, out of four or five thousand operations. In one case, probable embolism of the liver took place. The patient never passed bile-colored stools after the injection, and died in a few months of exhaustion and marasmus. Several cases of abscess of the liver were also reported, and a considerable number of sloughing, severe pain, hemorrhage and local abscesses. This, together with the lack of permanency of the cures, has led many surgeons to avoid the method, and others, like Kelsey, to abandon it after a thorough trial.

I have never entirely abandoned the injections, but have used them when a patient was found strongly predisposed in their favor, after explaining their advantages and disadvantages. Sometimes the results are highly satisfactory. Very recently, an elderly physician who had read my writings for and against the method, called at my office, and wished that it be used on him. He had a single hemorrhoid the size of a hickory nut, continually prolapsing, and at times nearly disabling him. For years he had made a daily practice of seeking a closet to replace it, several times a day, and had had the usual discomforts of such cases. I injected 5 minims of 4 per cent. cocaine into the tumor, and then without removing the needle followed this by 6 minims of 50 per cent. carbolic acid, in glycerine. The patient did not know when the needle was inserted or withdrawn, and was conscious of nothing being done, at all. In two weeks he reported with absolutely every vestige of pile gone. No slough had been known to separate, and no sign of granulating surface appeared. The changes were probably interstitial. It is such cases in the hands alike of quacks and reputable physicians which lead all parties concerned to become enthusiastic over the method. However, disappointments will come, as I have shown, to all who use the injections. It is a significant fact that the inventor of the method, after selling it, as a secret, for years, himself abandoned it for a kind of needling operation which, however, never became popular. (See Andrews' Rectal and Anal Surgery.)

From the partial success of this injection or coagulant treatment we may learn at least one lesson, viz., that to cure hemorrhoids it is essential only to destroy their internal varices, and that their mucous covering will not remain hypertrophied after this is done. The removal of the whole tumor is, therefore, unnecessary, from a surgical standpoint, if any method of destroying the veins alone can be found. The knowledge that destruction of these veins is a painless process, is also a valuable result of experience with injections.

If, then, some means may be found safely to obliterate the varix in each pile, a painless and effectual treatment will be at hand which can offer all the safety of the cautery, ligature or crushing operation, and at the same time will not require an anæsthetic or detain a patient from his business. Such a method, I believe I have found in the application of electrolysis to the destruction and coagulation of the interior network of vessels in hemorrhoids.

My attention was long ago called to the fact that moles and naevi about the face were quite painlessly destroyed by a certain manipulation of the needles.

In removing superfluous hairs by electricity, considerable pain is usually felt, as the current is applied. Where the number is large, I have even found it better to give an anæsthetic, and remove a larger number at one sitting. Accidentally, I discovered that this pain was far less if the electrodes were placed very near together, instead of having one placed in the hand or side of the face. The reason obviously is, that with less resistance interposed, a current of lower tension can be used.

In the case of moles or warts, if two needles connected with the battery poles are placed on oppoite sides of the growth and pressed toward each other, they will rapidly come together, and little pain be felt, while the growth turns black. If one needle only is used, the other pole being a sponge electrode held at a distance, the result on the growth is the same, but sharp, stinging pain is felt during the passage of the current.

In applying such a treatment to hemorrhoids, I therefore seek to pass the two

needle electrodes into a single pile, and to limit the coagulant and electrolytic action to the interior, and have endeavored to use the weakest currents which will produce good chemical action through a resistance of one-eighth to one-half inch of tissue. I may say that I regard the changes produced as purely chemical, exactly such as an injection of acid would produce. The current acts by destroying the life of cells, through its power of decomposing water, and this is nearly what caustics do, whether alkaline or acid, viz.: they destroy tissue through their affinity for water.

I have already stated, what every operator knows, that a needle can be inserted into a pile with little or no pain. A drop of cocaine will make this doubly sure, and a few drops more injected into its center will make the whole tumor insensitive for a moment or two. If then the hypodermic needle could become the negative pole of a battery and a circuit established through the tissue, coagulation and destruction could take place around the needle to a considerable extent, without involving the part containing sensory nerves, or, in other words, the mucous membrane.

My first experiments were made with a hypodermic needle and a syringe electrode, but the operation was not entirely painless, and I found difficulty in preventing the barrel of the syringe from coming in contact with the skin. My current was also too strong, causing more rapid evolution of gas than is needful. The experiment, however, showed me that the method had great possibilities, since I had no trouble in producing a hard coagulum in each pile treated. I noted, also, that there was less immediate swelling than with injections, in fact there appeared to be some contraction. In the hypodermic method, severe swelling and great pain sometimes appear on the second day. This is especially common with weak injections.

The next stage of my experimenting was in the direction of passing both positive and negative electrodes in the form of needles into the center of a pile, using a hypodermic needle as one pole, and making a preliminary injection of cocaine. The result of this was a painless operation and a quicker destruction of the veins, while the current used was only four elements, E. M. F., about six volts, against a voltage of twenty volts in the first case. The anumeter would register slightly higher (10–30 milliamperes) in the latter case, owing to the smaller resistance.

My present form of instrument contains no provision for injecting cocaine, but could be so arranged by making one of the needles hollow. The destructive action of the current very rapidly corrodes any but a platinum needle, and by using fine dental broaches I obtain almost entirely painless puncture. The hollow needle is so much larger as itself to be a little more likely to cause pain. My experience is as yet too limited to determine whether it will be better to rely only on external applications of cocaine. So far I have had little or no pain with the broaches. They corrode very fast, and must be renewed. Theoretically, a fine copper electrode would be desirable for the negative needle, as shown by the hardening and penetrating action of the copper salts with the uterine electrode.

The instrument shown herewith is as simple and practical as I have been able to make it, with my present experience as a guide. For internal deeper piles, a hooded or tubular end, like a speculum, would perhaps facilitate its use.

I have found this method a pleasant and efficient substitute for the hypodermic treatment. On theoretical grounds, I feel warranted in claiming that it will prove safe and that the cures will be permanent. Should clinical experience develop no cases of embolism, or other dangerous complications, I believe the method can do what the hypodermic method has failed to accomplish in superseding all operative measures requiring anæsthetics and confinement to bed.

A CONSIDERATION OF HEMORRHOIDS AND THEIR MEDICAL TREATMENT.

By FRANK S. PARSONS, M. D.
NORTHAMPTON, MASS.

HEMORRHOIDS may be considered a varicosity of the external or internal hemorrhoidal plexus of veins, from which we obtain the so-called varieties of external or internal piles.

When we consider the position, the

anatomical relations, the structure of these veins, and the customs and habits among civilized countries, it is most remarkable that we have as much freedom from this common surgical affliction as we do.

While searching for the cause of hemorrhoids, we must bear in mind the close connection of these vessels with the inferior vena cava through the internal iliac, the absence of valves in the hemorrhoidal plexus and their close anastomosis with the arterial system.

Then we can the more clearly see why a backing up of blood, or stasis in the circulation through these larger veins may cause dilatation and a varicose condition of the hemorrhoidal ones.

From this ordinary statement one receives a wrong idea of the cause of piles.

We must remember that hemorrhoids do not differ materially in their pathology from varices elsewhere in the system, and when we have a backing up of blood, or stasis in venous circulation about the portal system, or any other trunk of veins, we do not get the condition known as varices from the immediate dilatation and rupture of the ultimate veins of such plexus, but an œdema from diapedesis of serosity forced through the expanded walls of the vessel into the loose connective tissue, sometimes with escape of blood corpuscles. This is demonstrable in the œdema of pregnancy, when the uterus has risen sufficiently to cause pressure on the internal illiac veins.

We do not always obtain varicosities and hemorrhoids in pregnant women, and, if they occur, they are not the result of immediate or sudden pressure, but a distensibility of the walls of the vessels must exist combined with long-continued pressure.

Anatomically in varices we often see thickening of the walls of the affected veins from a connective tissue deposit between the muscle fibers.

Seemingly this does not take place on account of the enormous enlargement of the caliber of the vessels, but in reality such is the result of long continued pressure and diapedesis of wandering cells and their organization into new connective tissue. Therefore, stasis of the circulation is only an associated cause of the piles, where it occurs in the hemorrhoidal plexus, and not the sole cause.

Furthermore, this condition is not a result of one such stasis suddenly attained, but of long-continued pressure where no favorable exit for the blood in the distended veins exists from frequent anastomosis.

Piles are thus often the result of diseases of the heart, kidneys, and liver, where there is interference with the full return of blood through the portal system.

Congestion of the portal system may occur from high living, especially when the free use of alcohol is indulged in, as well as the inactive, sedentary life led by literary men and others; this is prone to the induction of piles.

Hereditary tendencies and cachexia may predispose to hemorrhoids from digestive disturbances and impoverished blood.

Constipation is inclined to produce dilatation and varices in the hemorrhoidal veins, not only from impaction and pressure of fecal matter, but also by the additional tension placed on them by the act of straining at stool.

While it is rare for children to become sufferers from hemorrhoids, yet age is no indication for immunity against the disease; congenital predisposition, and malformation of the viscera may occasion some few cases indirectly.

The symptoms of hemorrhoids are so well known that they would hardly be more than repetition in this place; however, it is well to call attention to the fact that an alarming hemorrhage may take place from an internal pile, which, while bleeding slowly, may cause a collection of blood to considerably distend the rectum before being expelled I have seen this occur to a point of syncope, before the real locality of the hemorrhage was obvious.

The medical treatment of hemorrhoids consists of palliative and curative measures. For it is possible to cure piles without the aid of surgical means. The palliative measures are directed to the relief of pain and controlling of hemorrhage, if any of importance occur.

External piles may be ameliorated by the use of topical applications of ice, opium, cocaine, and other useful adjuvants calculated to reduce the cellular

congestions and relieve the pain, and reduce the size of the tumor. Internal piles may be treated in a similar manner by suppositories and injections, in which various drugs are employed.

A mixture of tannin and opium often controls the hemorrhage of internal piles and relieves tenesmus.

Curative medication should begin by ascertaining the cause of the varicose condition of the hemorrhoidal veins, and its removal, if possible.

This involves treatment of co-existing diseases which may be inclined to produce or aggravate the stasis of portal circulation.

Attention to the diet and regulation of the bowels is of prime importance.

The object of this paper is to call attention to the treatment and cure of piles by absolute rest in bed, with the hips elevated.

This method is so simple, easy of performance, and effective, that the results are often astonishing.

Naturally, most patients object to it, for the time required for the cure of that affection is often wearisome, and unless it is absolutely followed out, the patient is not fully relieved.

The patient should be placed in bed with a pillow under the hips, or the foot of the bed raised so that all downward pressure is taken from the pelvis. It is necessary to keep the patient two or more weeks in bed for effective cure. The diet should be semi-fluid and of easily digested substances.

The after-treatment should consist of such tonics as will favorably act on the muscular coats of the vessels.

THE TREATMENT OF HEMORRHOIDS.

By S. T. ARMSTRONG, M. D., Ph. D.,
[Visiting Physician to the Harlem Hospital, N. Y. City.]

BEFORE entering into a consideration of the different methods of treating hemorrhoids, it will be well to define my position regarding their classification and ætiology. For all practical purposes the old division of hemorrhoids into external and internal is a satisfactory one, though either variety is often associated with the existence of the other. They occur as tumors formed in the mucous membrane of the rectum, near the anus, in either men or women, and their appearance is so familiar that no description is necessary.

Pathologically these tumors have been found to consist mainly of a hyperplasia of the rectal submucous tissue, and of saccules formed by morbid dilatations from the small hemorrhoidal veins. There may be in such tumors a predominance of fibrous tissue, or a predominance of tortuous and dilated arteries and veins. The latter formation is the usual characteristic of internal hemorrhoids, bleeding from which is so frequently the only symptom of their existence. Sometimes there is the rupture of a vein with moderate extravasation of blood into the submucous tissue of the rectum, and consequently there is a localized leucocytic activity, cellular proliferation, and connective tissue organization, such as occurs at any inflamed area.

Numerous causes have been assigned as the exciting factors of hemorrhoids; but in all the conditions that have been mentioned constipation is a prominent feature. The influence of constipation in exciting or perpetuating the hemorrhoidal condition, has by all observers been considered to be, in consequence of the mechanical irritation. But it seems to me that constipation produces another effect that has not, that I recall, been heretofore presented; and this effect is the vasomotor as well as muscular paresis that is produced by the local absorption of the leucomaines contained in the feces. That form of auto-intoxication that has been called stercoræmia exercises its primary morbid influence upon the hemorrhoidal vessels and nerves that results in an atonic condition of the rectum. In consequence of this toxic atony there is an abtusion of the rectum that is evidenced by its insensibility to fecal masses or to fluid injections of various temperatures.

It was acting on this hypothesis that I adopted in 1885 a plan of treatment that has proved to be satisfactory in a large number of cases. A relative, whose vocation as a civil engineer, kept him in regions where medical consultation was only possible by letter, wrote to me regarding the development of hemorrhoids as a consequence of poor cooking and a limited water supply. From the history he gave he had internal hemor-

rhoids; so the first requisite was to empty the rectum daily in order that there might be no prolonged accumulation of feces, and the next essential was to secure a local disinfection. For the first purpose the fluid extract of cascara sagrada was given in doses of a tea-spoonful at bed time each evening. For the rectal disinfection, injections containing 15 drops of carbolic acid in a pint of tepid water were taken after each evacuation. I later heard from the patient that the treatment had relieved the trouble, and directions were given that the rectal carbolized injections be discontinued and that the cascara sagrada be taken at any time that the bowels seemed to be sluggish.

This has proved an effectual cure, the patient reporting to me, early this year, that he had had no further trouble from hemorrhoids. He also stated that during the past seven years he had frequently used this treatment for men under his command and always with success.

During recent years I have modified this method in my hospital and private practice. The employment of the cascara sagrada has been continued in these cases either in the necessary dose of the fluid extract, in pills, in a mixture of the extract of malt with the fluid extract of cascara sagrada, or in the following prescription that I have found very serviceable:

℞—Fl. ext. cascaræ sagradæ, ℥iv.
Glycerinæ c. p., *ad* . . ℥ij.
M. et. ft. mistur. S.—One-half tablespoonful at bed-time.

The carbolized injections are made by adding to each pint of tepid water a teaspoonful of salt and two tablespoonfuls of this mixture:

℞—Acidi carbolici, c. p. . . . ℥iiss.
Glycerinæ, c. p. *ad*. . . . ℥viij.
M. ft. m. S.—Poison.

An injection of a quart of fluid prepared in the above fashion should be retained a few moments and then evacuated.

I conceive that this mixture not only acts as a local disinfectant, but that it produces that moderate constriction and anæsthetic effect that carbolized solutions cause when applied externally. Certainly in the general run of patients having a more or less pronounced hemorrhoidal tendency a carefully conducted treatment, as above outlined, will afford relief.

If the patient comes for our advice, and we find an angry-looking, protruding hemorrhoidal mass, a more decided plan of treatment is necessary. Hilton has shown (Lectures on Rest and Pain, Fifth Edition, 1892, page 292), a diagram of the course of the irritation caused by an ulcer on the sphincter ani, conveying the sensation of pain to the spinal cord, and producing upon the sphincter muscle reflected effects that lead to painful contractions. A similar route is followed, and reflex excited, by a protruding hemorrhoid, though the physiology is slightly different. In consequence of straining, there is a temporary extrusion of the mucous membrane covering and just within the sphincter ani; if there is a hemorrhoid in this membrane, it is arrested by the contracted sphincter, while the rest of the mucous membrane is retracted within the anus. The mucous membrane covering the hemorrhoidal mass is made tense, its vessels quickly become engorged, and, in consequence, we have the same reflexes excited as those described by Hilton. Such a patient should have the rectum cleaned out at once by a warm carbolized injection; the hemorrhoidal mass should be cleansed with a five per cent. carbolized solution, and from ten to thirty minims of that solution should be slowly injected into the pile by means of a hypodermatic syringe. The patient should subsequently keep quiet, preferably lying down; and if the hemorrhoid is too large or too painful to replace within the sphincter, compresses, wet with a five per cent. carbolized solution, or with fluid extract of hamamelis, should be placed over it. Either of these liquids greatly relieves the local pain, though in women it is sometimes necessary to administer an injection of morphine. At intervals of three or four days injections of the necessary quantity of a five per cent. carbolized solution should be made into the hemorrhoid until the mass disappears in consequence of absorption and connective tissue formation.

My attention was called to this method of treatment in 1879, by D.. J. R. Weist's report on the subject (Transactions American Medical Association, 1879, Vol. XXX., p. 499). At that time

I was employing carbolic injections in the treatment of buboes and arthritis with gratifying results, and in no instance (except that of buboes) did any suppuration or other untoward accident follow such an injection. It has been my good fortune to have no unfortunate sequence to these injections; and there is no good surgical reason that harm should follow them. Of course it has been the experience of excellent physicians that comparatively insignificant surgical procedures are followed by serious consequences; but I do not believe that this is more frequently the case in intra-hemorrhoidal carbolized injections, than it is in circumcision, or incision of an abscess. Many surgeons will dissent from the extreme prejudice of Dr. Kelsey, who has recently written: "Carbolic acid injections will almost invariably lead to suppuration." My own hospital experience during the past fourteen years, would lead me to say that these injections never lead to suppuration; but it does not seem desirable to make so arbitrary an assertion, and presumably Dr. Kelsey is a careful operator, and suppuration has occurred in his cases. There is no more danger of carbolic embolism than there is of air embolism.

If in these cases in which carbolized injections are employed there is considerable irritability, it will be well to make applications of a two and-a-half or five per cent. ointment of carbolic acid within the rectum. This may be done by means of an ointment applicator of hard rubber, or by means of a flexible tube of carbolized vaseline having a short blunt-pointed pipe that will not injure the membrane.

Where there is reason to suspect the existence of internal hemorrhoids it is best to have the patient take a laxative at bed time and after the bowels are evacuated the following morning to clear the rectum by an injection of tepid water, so that the clean mucous membrane may be carefully examined when the patient is seen by the physician. With men I find the knee and elbow position most convenient for making a rectal examination; with women the lateral position. The physician should first examine the rectum by introducing a well warmed and oiled finger, so that he may discover the location and character of any intra-rectal lesion. After satisfying himself in this regard, the rectum should be exposed by introducing slowly and gently a well warmed and oiled fenestrated rectal speculum. The physician should carefully examine the rectal mucous membrane by means of a head mirror, and natural or artificial illumination. Having located the hemorrhoids the subsequent procedure will depend upon their character.

For small masses the carbolized injections may be employed as above directed. But in those flat, granular hemorrhoidal masses the most satisfactory procedure is an application of Paquelin's thermo-cautery, a procedure that will demand the administration of an anæsthetic. The surface is dried by means of some absorbent cotton wound about a probé, and the cautery, first heated to a cherry red, is drawn over the granular surface, carefully avoiding any injury to the healthy membrane. The results from the cautery are quite as good as those that I have observed from the employment of nitric acid.

In the case of larger hemorrhoidal masses they should be caught in a pile-clamp, the instrument screwed tightly and the mass carefully turned outside of the rectum; the upper portion of the mass should be cut off, and the incised surface seared with the thermo-cautery until the eschar is sufficiently dense to prevent bleeding. Subsequent rest in bed and local treatment should be that usually directed.

There are certain cases in which various causes have contributed to produce a rectum that is pouch-like and that protrudes after each evacuation from the bowels. There is a hyperplasia of tissue and none of the methods above specified will afford anything but a temporary relief. I have performed Whitehead's operation in such cases with relief to the patient. The description of this operation may be found in any of the recent text books of surgery.

No hard and fast rule can be laid down for the treatment of hemorrhoids, because, as in all other diseased conditions, each case should be treated upon its particular merit. Furthermore complications of a fissure, a fistula, or an ulcer may demand different treatment of the hemorrhoid from that that would be adopted under ordinary circumstances. My main

object in this paper has been to call attention to the influence of local irritation in consequence of the absorption of the effete fecal products in perpetuating the hemorrhoidal condition, and the necessity of an antiseptic treatment to relieve this irritation.

166 WEST 54TH STREET, NEW YORK.

THE TREATMENT OF ANAL FISSURE, OR IRRITABLE ULCER OF THE RECTUM.

BY LEWIS H. ADLER JR., M. D.

[Read before the Philadelphia County Medical Society, November 25, 1892.]

THERE are some general rules that must always form a part of the treatment of anal fissure, to wit: to lessen as much as possible any inordinate action or distension of the bowel, and to prevent the ulcerated surface being irritated and abraded by the passage of hardened feces.

To fulfill these indications enemata or mild aperients should be employed, and the diet must be regulated, the use of bland and unirritating food being enjoined.

It is not possible to point out a diet that would be even generally applicable, as so much must depend upon the state of the constitution and the previous habits of the patient; but in general it should be moderate in quantity, yet sufficiently nutritious—what the stomach can digest with ease, and has no tendency to produce constipation.

The patient should be directed to take moderate exercise; and if the bowels are disposed to be costive, a daily evacuation should be secured by the administration of an enema of warm water, or one of rich flaxseed tea, say from half a pint to a pint, to be given every evening, preference being given to the night time as the patient can then assume the recumbent posture, which, combined with the rest, affords the greatest protection from subsequent pain.

Instead of the enema, or in conjunction with its use, the action of the bowels may be regulated by the employment of some mild aperient, such as the patient has found by experience to agree with him.

All drastic purges should be avoided, as they are more or less stimulating and irritating to the extremity of the rectum. The pain and spasm of the sphincter muscles attending the evacuation of the bowels is best relieved by the use of a suppository consisting of—

℞.—Ext. belladonnæ . . . . . gr. ⅛ to ½.
Cocain. hydrochlor. . . . . gr. ¼ to ½.
Ol. theobromæ . . . . . gr. x.
Misce et ft. suppositoria j.

One suppository to be employed about half an hour before the enema is given, or a movement of the bowels is expected.

Instead of the suppository, an ointment of extract of conium may be used, as recommended by Mr. Harrison Cripps.[1]

℞.—Ext. conii . . . . . ℥ij.
Olei ricini . . . . . f℥iij.
Ung. lanolini . . . . . q. s. ad ℥ij.—M.

A small quantity of this ointment should be smeared over the parts five minutes before a passage, and again after it has occurred.

The various methods of treating anal fissure may be divided into the *palliative* and the *operative*.

PALLIATIVE MEASURES. — Palliative treatment will meet with success in cases in which the fissure is tolerably superficial and of somewhat recent origin, especially when there is no great hypertrophy of the sphincter muscles.

Allingham[2] states that the curability of the lesion does not depend upon the length of time that it has existed, but rather upon the pathological changes it has wrought. This same authority states that he has cured fissure of months' standing by means of local applications when the ulcers were uncomplicated with polypi or hemorrhoids, and when there was not marked spasm or thickening of the sphincters.

It is essential to the success of the treatment of fissure, especially by local applications, that rigid cleanliness of the parts be maintained; for this purpose the anus and the adjacent portions of the body should be carefully sponged night and morning, and after each stool, with hot or cold water, the temperature being regulated to suit the patient's comfort.

In applying the various local remedies it is necessary first to expose the ulcer to

[1] Diseases of the Rectum and Anus, second edition, London, 1890, page 189.

[2] Diseases of the Rectum, fifth edition, London, 1888, p. 215.

view, and to anæsthetize its surface with a four or eight per cent. solution of cocaine hydrochlorate, well brushed in with a camel's-hair pencil.

The application may have to be repeated once or twice, at intervals of about five minutes, in order to obtain the desired anæsthetic effect.

If any ointment has been used about the fissure, the anus should be subjected to a hot water douche before using the cocaine, as cocaine will not exert its anæsthetic influence on a greasy surface.[1]

Among the different remedies that have been used in the local treatment of fissure of the anus may be mentioned the following: Nitrate of silver, acid nitrate of mercury, fuming nitric acid, carbolic acid, sulphate of copper, the actual cautery, and chloral hydrate.

Of these topical applications the nitrate of silver is the best. Its effects are various: it lessens or entirely calms the nervous irritation, which is so important a factor in producing spasmodic contraction of the sphincters; it coats and shields the raw and exposed mucous surface by forming an insoluble albuminate of silver; it destroys the hard and callous edges of the ulcer, and tends to remove the diseased and morbid action of the parts.

The form in which the salt is usually employed is in solution (from ten to thirty grains to the ounce). The stick caustic may be also used.

To accomplish the best results, the solution should be used once in twenty-four or forty-eight hours, according to circumstances. It may be applied by means of cotton attached to a silver probe or to a piece of wood.

The application is made by separating the margins of the anal orifice with the thumb and index finger of the left hand, and introducing into the anus the probe charged with the solution. The argentic nitrate is to be applied to the fissure only; a few drops are all that is required. If thorough local anæsthesia has been induced by the use of cocaine, the application of the silver salt produces little, if any, suffering, for by the time that the anæsthetic has lost its effect, the otherwise acute pain of the nitrate of silver will have passed away.

After each application the part should be smeared well with an ointment of iodoform (thirty grains to the ounce). The odor of that drug may be disguised by the addition of a few drops of the attar of roses. Iodol may be used instead and in the same way, but I prefer the iodoform, owing to its anæsthetic qualities. After the ulcer has been touched once or twice with the silver solution the effect will be, in the cases that are benefitted by this treatment, a considerable mitigation of the pain from which the patient suffered when at the closet and afterward, and the sore will present a healthy, granulating appearance, and will slowly contract in size.

Some authorities speak highly of the use of acid nitrate of mercury, fuming nitric acid, carbolic acid, the actual cautery, etc., but their employment, with the single exception of carbolic acid, is attended with more suffering than follows the use of the nitrate of silver or the simple operative treatment presently to be described. Furthermore, the application of these remedies is not so certain to effect a cure as either of the two procedures just mentioned.

The daily introduction of a full-sized bougie made of wax or tallow, will sometimes act beneficially in cases of fissure by stretching the sphincter and producing such an amount of irritation as will set up a healing process in the ulcer. An application of cocaine or belladonna ointment should be made to the part previously to the employment of the bougie.

In children and young persons, unless a polypus or a polypoid growth, or a congenital contraction, complicates the fissure, it is almost always curable without operation. In children suffering from hereditary syphilis, numerous small cracks around the anus are common, and they cause much pain. Mercurical applications and extreme cleanliness soon cure them, but they will return from time to time unless anti-syphilitic medicines be taken for a lengthened period.[1]

OPERATIVE TREATMENT.—If, after a fair trial of the simple measures that have been recommended, the fissure does

[1] W. P. Agnew, M.D.: Diagnosis and Treatment of Hemorrhoids, etc., second edition, San Francisco, Cal., 1891, p. 91.

[1] Allingham, op. cit., p. 213.

not heal, or if, as described by Allingham,[1] the base of the ulcer be gray and hard, and if on passing the finger into the bowel the sphincter be found hypertrophied and spasmodically contracted, feeling, as it often does, like a strong india-rubber band with the upper edge sharply defined, or if there should be a polypus, polypoid growth, or any other complication, local treatment will not effect a cure and operative interference will be rendered necessary.

There are three methods of repute to be considerd in this connection; incision, forcible dilatation, and a combination of these two procedures, viz.: dilatation and incision.

Incision. A fissure can be cured by making an incision through the base of the ulcer and a little longer than the fissure itself, so as to sever all of the exposed nerve-filaments and muscular fibres along the floor of the ulcer. In a certain proportion of cases this operation will meet with success, but it is not so certain and radical as the third method to be described.

It has the advantage over the other two operations, however, of being nearly or entirely painless under local anæsthesia produced by cocaine, and, therefore, when general anæsthesia is contraindicated, or is refused by the patient, this method is worthy of trial.

Forcible dilatation. This is the operation recommended by Recamier, of Paris; Van Buren, of New York, and others.

It consists of the introduction of the thumbs into the bowel, back to back, and then forcibly separating them from each other until the sides of the bowel can be stretched as far out as the tuberosities of the ischia. It is well to place the ball of one thumb over the fissure and that of the other directly opposite to it, in order to prevent the fissure from being torn through and the mucous membrane stripped off. As pointed out by Allingham,[2] it is well to repeat the stretching in other directions until the entire circumference of the anus has been gone over. In this manner, by careful and thorough kneading and pulling of the muscles the sphincters will be felt to give way, and will be rendered soft and pliable. This procedure should always be practiced with the patient thoroughly under the influence of an anæsthetic, and it should occupy at least five or six minutes. The operation is a perfectly safe one, but as it is no less severe than the method by incision, and as it fails to effect a cure in some cases, I can see no advantage in adopting it instead of the more satisfactory and always successful plan of treatment—combined dilatation and incision. It may be found preferable, however, in some cases on account of the prejudice of patients against the use of the knife.

Rapid forcible dilatation for the cure of fissure is a method now tried by some surgeons and *apparently* with a fair measure of success.

The patient is placed under the influence of nitrous oxide gas, and the sphincters are quickly stretched either by manual force or else with instrumental power. For my part, I do not see how a satisfactory dilatation can be accomplished in this way. When the cure of fissure by dilatation is attempted under ether-anæsthesia—the muscular system being completely relaxed—the thorough paralysis of the sphincters occupies several minutes before they are felt to yield, and the strain upon the operator's thumbs incident to the operation, becomes very tiresome, to say the least.

With anæsthesia produced by nitrous-oxide, we obtain a suspension of muscular action, but no general muscular relaxation; hence, to suspend the function of the sphincters to such a degree as to remove the cause which prevented the healing of the ulcer, viz.: the constant motion of the muscular fibres, we must exert a force which would be both detrimental and dangerous to our patient's welfare. Therefore, I cannot believe that this plan of treatment will be commended by the conservative surgeon.

Dilatation and incision. This method I believe to be a radical and unfailing cure for anal fissure, if skillfully and carefully performed. The following are the details of the operation: The bowels should be thoroughly cleansed by the previous administration of a dose of castor oil and an injection: after which, under ether-anæsthesia, the sphincters should be dilated in the manner previously described.

[1] Op. cit., p. 217.
[2] Op cit., p. 226.

The resulting hyper-distention of the anus not only affords rest to the parts, by the temporary paralysis of the muscles, but also, as pointed out by Van Buren, it stretches the sensory nerves of the anus, so that they cease for the time being to convey impressions, the result of irritation, to the nerve fibres exposed in the floor of the ulcer; in the same way that we find forcible stretching of the sciatic and the sensory branches of the fifth nerve, relieves neuralgia.

Mr. Charles B. Ball[1] states that this theory of the temporary cessation of the function of the sensory nerves following the hyper-distension of the bowel receives considerable support from the fact which is frequently observed, that the first time the bowels move after the dilatation there is entire immunity from the pain which before was so severe.

The first step in the operation being accomplished—the dilatation of the sphincter—it will enable us to obtain a complete view of the lower end of the rectum and the exact limits of the ulcer. The fissure is now kept exposed by the fingers of the left hand, and a probe-pointed bistoury is drawn through its base, from within outward so as to incise the subjacent muscular fibres at right angles to their course. It is well to begin the incision a little above, and to end it a little below the ulcer, so as to insure its being carried quite through the sore.

Another method is that advocated by Mr. Syme, and is performed by transfixing the ulcer beneath its base with a small, sharp-pointed, curved bistoury, and cutting from without inward. This procedure endangers wounding the opposite side of the bowel unless it is protected.

The subcutaneous division of the sphincter, as recommended by some authorities, is not a satisfactory method, and is mentioned solely for the purpose of condemnation. It is not only uncertain in its results, but it is also painful, and in more than one instance has been followed by abscesses.

In cases in which the fissure is situated in the median line of the rectum, either anteriorly or posteriorly, care should be observed in making the incision, for the reason that wounds towards the coccyx split and separate the fibres of the external sphincter only, and are difficult to heal, while anatomical considerations will deter us from using the knife freely anteriorly; in the male from the bulb of the urethra being in close proximity, and in the female the shortness of the perineum, and the knowledge that division of the anterior fibres of the sphincter in women is so frequently followed by incontinence of feces

After any of these the patient should keep the recumbent position, and it is better to confine the bowels with opium, at least for the first forty-eight hours. After three or four days a laxative, followed by an enema, may be given, from which time daily alvine movements should be secured. In seven or eight days the patient can begin to move about, but for at least two weeks he should avoidstanding too long on the feet. No dressing is required, except a small quantity of iodoform, which should be dusted over the ulcer, and the parts should be bathed well with warm carbolized water, night and morning, to remove offensive discharges.

Peroxide of hydrogen (Marchand's) may be used instead of the carbolized water.

In the majority of cases of fissure, healing progresses with great rapidity, but occasionally, after the wound has healed to a certain extent, healthy action stops, and the appearances of an anal ulcer are again produced. Should this occur, it will generally be found that some complication has been overlooked, such as a fistulous passage running from the ulcer beneath the mucous membrane of the bowel.

The presence of such a passage might be suspected, if the discharge from the part is out of proportion to the size of the ulceration.

Another complication consists of a small hypertrophied tag of membrane, or polypoid growth, situated at the base of the fissure, or on some other portion of the rectal wall.

The removal of these complications will aid the patient's recovery.

[1] The Rectum and Anus, p. 136.

[1] T. J. Ashton: Diseases, Injuries, and Malformations of the Rectum and Anus, etc., second American from the fourth English edition, 1865, pp. 49, 50.

[2] Mr. Harrison Cripps: op. cit., p. 190.

The Times and Register.

A Weekly Journal for Medicine and Surgery.

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PHILADELPHIA, DECEMBER 10, 1892.

WE herewith present to our readers one of our best special editions. Every article is practical and is written by men whose opinions are valued by the profession. Week after next we send out a second 'Typhoid Fever" number, with a number of valuable articles. On December 31st, the journal will be devoted to the treatment of pulmonary phthisis. It would be difficult to select three more interesting subjects for the general practitioner. Rectal affections are very common, and very much neglected. Hence comes the success of quacks, like the Brinkerhoff and similar enterprising exploiters. Nothing but the universal neglect of rectal cases by regular physicians can account for the popularity of those illiterate vagabonds, who swarmed over the country, with their little syringes, injecting every perineum that was exposed to them with scarcely a pretense of the knowledge that would entitle one to treat rectal diseases. Still we believe these people did some good by arousing the profession to a sense of its shortcomings. We hope so, at least. The number of papers collected for this number is so large that several have been laid over for next week; among them two excellent papers from the Philadelphia County Medical Society, upon rectal diseases.

* * *

As many thousands of extra copies will be distributed during this month, we look for a material increase in our subscription list. We expect the hearty support of the medical profession, and propose to earn it, by issuing during the year fifty-two numbers of the TIMES AND REGISTER, each equally as good and *useful* as the present one. During 1892 we issued special numbers devoted to diphtheria, pneumonia, cholera infantum, typhoid fever, cholera, gonorrhœa, resorts for consumptives, Summer health resorts, etc. Of these, scarcely a copy remains in our files, so great has been the demand for them, while many applications we have been unable to fill. Would it not be wiser to subscribe for the journal and get all the special issues without taking any chances? We have now in preparation numbers devoted to gleet, surgical appliances, medical education, affections of the eye, ear, nose and throat, as treated by the general practitioner, rheumatism, croup, whooping cough, etc., etc. At the same time whenever any affection threatens to become epidemic, as cholera did last summer, we are ready to make it the subject of a special number. From the growing interest in these issues we believe we can safely promise our readers that the coming year will give them a better journal than in the past. We now issue the cheapest medical journal in the United States; it is our determination that it shall also be acknowledged to be the most useful.

Letters to the Editor.

HEMORRHOIDS.

EDITOR TIMES AND REGISTER: I prefer now the clamp and cautery to all other surgical methods for the radical removal of circumscribed hemorrhoidal tumors. Where there exists a condition that is sometimes found, in which no distinct hemorrhoidal tumors are seen, but instead a general varicose condition of the whole circumference of the lower rectum, Mr. Whitehead's operation is undoubtedly the correct surgical procedure.

GEO. H. KIRWAN, M. D.
12 SOUTH WASH ST., WILKESBARRE, PA.

VESICAL IRRITABILITY.

PLEASE pardon me for intruding on your time in this manner, but I have a case, that though seemingly simple, yet is one which I do not understand. My patient is a little girl about four years old. She has been troubled about one year with her bladder. Almost every day during the day, and at nights sometimes, she has a constant desire to pass her water. She does not have incontinence.

If she has diarrhea, or a cold in the head, her urine does not bother her. I cannot arrive at a satisfactory explanation of this case. She seems quite healthy, well nourished, urine apparently normal, possibly too acid.

Have tried various remedies, nearly all seem to benefit her while taking them, but the result is not permanent. An answer will greatly oblige,

JNO. A. BRYANT.
WEST POINT, ILL.

[The case is incomplete. Has the child uric acid or the eczematous diathesis? In the first place, an attack of catarrhal inflammation might relieve the bladder temporarily. Secondly, a retrocedent eczema is quite rarely followed by genito-urinary irritability. It would be well to examine the vagina and urethra, and even the bladder, as there may be a calculus. If no local cause is to be found, look to the digestive organs, and see if there is not an indigestion of starches, or an over-eating of albuminous food. If so, the regulation of the diet, maltine, hydrochloric acid before meals, and a little salicylate of soda, are the remedies to be selected. If no such cause can be detected, the irritability may be relieved by salol or benzoate of lithia with belladonna.—ED. T. & R.]

SUGGESTIONS FOR SPECIAL ISSUES.

IN reference to my choice of subjects for special numbers of THE TIMES AND REGISTER, I would suggest Pertussis, Membranous Croup, and Cerebro-spinal Meningitis, in the order in which I have named them.

A. N. SPURGEON.
KOSSUTH, IND.

[We hope our readers will imitate Dr. Spurgeon, and tell us what subjects they desire to see treated in the special numbers of the coming year. If each one will inform us what he prefers, we will take pains to secure the materials from the best available resources, beginning with the subjects that are requested by the greatest number.—ED. T. & R.]

THE ATMOSPHERIC TRACTOR.

PLEASE tell me if you know whether the Atmospheric Tractor and Uterine Safety Tube advertised by P. McCahey, M. D., of 1413 South Tenth Street, Philadelphia, are any good, and whether you consider them useful instruments in obstetrics.

C. C. GENTRY.
ELKTON, VA.

[The Tractor I have occasionally employed with advantage; of the Safety Tube I cannot speak from experience.—ED. T. & R.]

IODOFORM VERSUS ARISTOL.

EVER since the custom of using iodoform has been in vogue, I have almost always, until a little more than a year since, used this "antiseptic" as a wound protective.

I never felt, during this long period of time, in which I have used this remedy thousands of times, that I ever got results that would warrant one in so persistingly following out the dictates of modern surgical notions, unless it is that in this remedy we have a "stink that outstinks any other stink," which was said to be the great desideratum in the vain endeavors of those who believed that it was from without (the surrounding atmosphere) the poison coming in contact with raw surfaces, brought about the condition which prevented primary union by wound infection, and thereby causing sloughing, local and even general systemic infection—sepsis.

I adhered, however, blindly I may say, to the teachings of the many, and con-

tinued the use of iodoform, not however, that I had the least confidence in the drug as an antiseptic or protective, as I had given wounds other protections which I considered of paramount importance.

The dressings which I have used in the way of absorbent dressings were gauzes, absorbent pads, and bandages such as were introduced to the profession by the late Mr. Sampson Gamgee, of England, and to the bandages and their proper application I must give a very large amount of credit for the attendant success in obtaining primary union in wound dressing.

I fully believe that most wounds, irrespective of their cause, whether from the surgeon's knife, the crushed wounds from machinery, wounds caused by fractured bones protruding through the soft parts, railroad and gunshot wounds, or other forms of injury, may mostly be made to heal primarily, by the proper application of pads of absorbent materials, and by bandages properly applied, after the fractured bones have been adjusted, and the sides of the wounds of the soft parts, regardless of how they were caused, have been properly brought into apposition by means of sutures and other forms of retentive dressing; and this, mark you, without the use of any antiseptic material whatever except plenty of water, which is a most reliable remedy to bring about an aseptic condition of any wound; and we are thus furnished an antiseptic remedy, *par excellence.*

I have always regarded iodoform as being at least harmless, but in due time a number of cases of systemic infection, produced by the absorption of poisonous quantities of the drug, occurred in my practice, and I was compelled to change my views. The symptoms of one of these cases, I related in the issue of the *N. Y. Medical Journal*, bearing date April 26th, 1890.

The other cases were equally annoying, and I stopped the use of the drug entirely, except where I was operating for other physicians who felt that iodoform was the very "balm of Gilead."

In those cases I reluctantly peppered the spot with the odoriferous material.

At the time aristol was first brought to the notice of the medical profession, after considerable wrangling for and against the use of antiseptics of any kind or nature, I was persuaded to try a sample package of it.

I very soon became anxious to try the remedy, for in opening the package I recklessly disturbed the contents and emptied them over portions of my clothing, and the manner in which the preparation stuck to my garments led me to conclude that its adherent virtues would at least make it a very reliable remedy as a protective.

The principal advantage I found at that time was the entire absence of any disagreeable odor.

(This absence of odor makes the aristol far superior to the iodoform as an elegant dressing).

On the following day I removed a cancerous mammary gland from a patient, in whom it was necessary also to open up the axilla to remove the diseased contents therefrom. Drainage tubes were placed; the extensive wound surfaces dusted with aristol; the edges of the wounds approximated by continuous suture; and the entire line of wound approximation again dusted with aristol; and then large pads of absorbent material were placed over the wound throughout its entire length through which the drainage tubes were then passed. The dressings were retained in position by carefully placed bandages, and by means of them the arm of the affected side was put at rest. In twenty-four hours these bandages were removed to enable me to withdraw the drainage tubes, which was done without disturbing the dressings proper, and then the bandages were re-applied, and the parts were not further disturbed until the eighth day following, when it was found that primary union had taken place throughout the entire extent of the wound. The aristol was found to have made a most excellent protective along the line of union, acting very much like a light gluey material.

This experience encouraged me very much, and since then I have resorted to the use of aristol in the dressing of all wounds or lacerated surfaces, whether on the exterior surface of the body, or in the cavities of the body, as in diseased conditions of the nasal cavities, the ear, the vagina, and the lacerated conditions of

the cervix uteri, after the repair of which I have always dusted the sutured parts most thoroughly with aristol.

In all operations about the anus and in the rectum, especially in the ligation, or after removal by cautery, of hæmorrhoids and in fistula and fissure, I have found this remedy of great value. In diseased conditions of the female urethra, more particularly cystitis, in dressing the wound made by Dr. Emmet's buttonhole operation, for the relief and treatment of such conditions, I have found that aristol gives a perfect protection from the irritating effects of the urine, to the line of the union made by the approximation of the mucous edge of the urethral lining to the vaginal edge of the wound. I have found that patients treated by dusting aristol over these wounds after the operation and before each act of urination, suffered much less than those whom I have treated after the manner taught by Dr. Emmet, viz.: that by the application of the cerate of impure carbonate of lead, or other form of fatty substances.

In all of my cases of both internal and external perineal urethrotomy and in all cutting operations for removal of stone in the bladder, I find aristol to be of additional value to the other generally recognized principles of wound protection in such like surgery.

In two cases of supra pubic cystotomy, one for the removal of stone, the other for the relief of symptoms, due to an enormously enlarged prostate, by cutting off the encroaching middle lobe by means of Gœlet's new prostatectomy scissors, I found that in spite of the drainage instituted byTr endelenburg's "T" drainage tube, thewoun d surfaces were overflowed by urine in the spasmodic efforts of the bladder to rid itself from the foreign effects of the drainage tube.

In the first of these two cases I found that the aristol gave perfect protection to the parts from the irritating effects of the urine and the wound soon healed without any infiltration of the surrounding cellular tissue.

In the second case I united the edges of the bladder wall to the edges of the skin, as originally recommended by Emmet, in his method of vaginal drainage of the bladder for the relief of cystitis.

The parts were then thoroughly dusted with aristol, and further protected by other dressings.

The central line of union as necessitated by the closure of the incision likewise the elliptical line made by the folding in of the cutaneous edge of the wound to meet the bladder edge, soon healed without sloughing or any other evidence of tardy union.

The aristol is still used by the patient to protect the parts from scalding effects of the urine, which he soon feels if he is careless about application.

In this case, as has been my custom since using aristol, I anointed with aristol ointment in vaseline, the wounds used to retain the normal calabre of the diseased penile urethra. This calabre was obtained at the time of the operation by Otis' method of internal dilating urethrotomy, and afterwards by a process of gradual dilatation by sounds of the strictured deep urethra, passing over the cut surface of the prostate.

I find that by the this use of aristol, wounds made by internal urethrotomy, and indeed all other wounds so treated, cicatrize with great rapidity.

In connection with this I will add that after a recent operation in which I crushed for stone, the bladder tenesmus and disuria were out of all proportion to the violence, which was moderate, used to crush the stone and remove the debris.

The patient suffered extremely,nothing giving relief, until I carried down to the bruised surface of the prostate by means of Reginald Harrison suppository carrier, a suppository composed largely of aristol. Within an hour after this application the patient received complete relief.

The powerful effects of aristol, to produce rapid cicatrization, in which large extents of ulcerated or wound surfaces are exposed, led me to resort to what I have long believed to be the ideal operation for the relief or possible cure of malignant disease when situated in the female mammary gland. This operation is the total ablation of the breasts by cutting wide of the mark, so to speak; in other words, going beyond the limits of the gland boundary with its accompanying fat and then allow the wound to heal by cicatrization without any attempt at bringing the parts together by means of sutures, the introduction and tension of which

both tend to defeat the sought for end. So in my last six operations for removal of the breast I have been following out this method and have by the aid of aristol met with astonishing results. I will give one case as an illustration, Miss —— aged thirty-three, suffering from cancer of the right breast, a cystic sarcoma of great size. She first consulted me at my office. She was suffering intense pain, due to tension of the parts. The peculiar appearance at first sight, suggested a deeply seated or sub-mammary abscess, lifting the breast forward. Upon examination and from the history of the case, I soon determined the nature of the growth. I at once, of course, recommended the removal of the breast and the contents of the axilliary space, which were likewise extensively involved. She agreed to the operation, and stated that she would return the day following, that I might appoint a day for the operation. This, however, she did not do. Several days afterward I received an urgent message asking me to go to her house as she was too ill to come to me. I found her in a state of intense misery. The parts were much more tense than when I had last seen her and there were several slight scars over different portions of the mass, which I at once recognized as the results of the efforts of some one to obtain pus. My suspicions were verified by the woman informing me that such was the case. She was now suffering from a condition of marked sepsis, probably due to the introduction of a non-asceptic needle.

I informed her that for the present her condition would not warrant operative procedure, and that before the operation her present symptoms must be relieved. This I succeeded in doing by repeated full doses of salol, morphia hypodermically with local application of an inunction of a twenty per cent. icthyol ointment in lanoline. At the end of a week she was free from fever but in a very depressed condition. I determined, however, to give her an only chance, and proceeded with the operation. I rapidly removed the entire breast, by a clean circular sweep of the knife, held in the left hand, beginning at the interior border of the large pectoral muscle, thence beneath the gland, keeping fully an inch outside of the extreme border, around the sternal portion of the proposed line of incision, thence above the breast back to the starting point. This incision went down through the pectoral fasciæ, which now with the gland, was quickly removed. The incision was now prolonged up through the axilla, to the biceps, following the line of the pectoral muscle. The entire diseased contents of this space were carefully, but as quickly as possible removed. The axillary space was thoroughly douched with hot, distilled water, as was the entire wound surface. The haemostats used in controlling the hemorrhage were removed, and a perfectly dry wound was now to be seen. The only suture used was a continuous one of asepticised silk which was used to retain in apposition the edges of the axillary incision. The cavity thus formed was filled with moist gauze, covered with aristol. No other form of drainage was used. The extensive wound surface, left by the removal of the gland, was now thoroughly dusted over with aristol, and further protected by gauze pads and absorbent cotton, which were retained in place by systemic bandaging, holding the arm, fore-arm, and the pectoral muscles at rest. The operation was neither attended with nor followed by any shock. The dressings were not disturbed until the eighth day, the patient during this time, being perfectly comfortable. When the dressings were removed, it was found that the axillary line of union was complete. The gauze packing was removed from the axillary space, the continuous suture was removed, and the united parts were allowed to fall into place. The breast surface had healed to a surprising extent and was perfectly free from pus as was the axillary space. The wound was redressed, first dusting over with aristol, and then not disturbed for another week, when it was again removed, this time in the presence of Dr. George H. Kirwan, of Wilkes-Barre, who was one of the assistants at the operation, and had now come to see to what extent the wound had healed. Dr. Kirwan, as well as myself, was greatly pleased, and expressed considerable surprise that in so short a time such an extensive cicatrization could have taken place. The wound was dressed weekly until it had entirely cica-

trized, which result was obtained in about eight weeks. During the redressing of this wound, there was no pus to be seen, with the exception of a light coating of so called granulation pus. The results which I have obtained in the use of aristol as a protection to wounds and ulcerated surfaces, and also as a stimulation to granulation, have been satisfactory to an extreme degree.

In all my cases of abdominal surgery I now use aristol and find it to be the ideal protective, having had no cases of breaking down of the wound made for the purpose of entering the abdominal cavity such as I have had happen in several cases where I have used iodoform.

RICHARD H. GIBBONS, M. D.
SCRANTON, PA.

The Medical Digest.

ANAL ABSCESS.—Reclus treats these as fistulas. Having opened the abscess, he introduces a channeled sound, to the highest point of the cavity, perforates the rectalmucora, and brings the sound out at the anus; the tissues being then cut through. Since it is necessary to produce a fistula, the abscess should be treated as a fistula at once.

ANAL FISTULA.—Do not operate on any fistula that can be tolerated. Make the clothing loose, the stools soft, and enforce cleanliness. After each stool, insert a suppository compound of iodoform, gr. jss.; ext. belladonna, gr. ⅓; and cocoa butter. This should also be inserted on going to bed. The reconstituent treatment consists of the use of bromides with iron:

℞—Potassii bromidi, gr. cl.
Ferri ammonio-citratis, gr. vijss.
Syr. aurantii amar. corb, ℥iij.
M.S.—A dessertspoonful morning and evening
—*Félix Guyon.*

RECTAL CANCER.—In certain forms, when the cancer progresses very slowly, and does not completely obliterate the bumen of the bowel, administer purgatives, prescribe lavages of the intestine, and a vegetarian diet. In these cases, the antiseptic medication is applicable, and permits the patient even to grow fat, and to live relatively very well, considering the lesions present.—*Dujardin-Beaumetz.*

HEMORRHOIDS.—Above all, prevent purging. Diet is essential, with an active life and avoidance of constipation; not by drastics, that increase the evil, but by laxatives, such as castor oil, sulphur alone or with cream of tartar, or magnesia in doses of 7½ grains every morning.

If there be intense congestion, or hemorrhage, enjoin rest in the horizontal position, and internal astringents. There is good reason in employing cold enemas, given without violence. Hobenemas are also useful, as hot as can be borne, repeated many times daily; they afford a notable and enduring relief. If these means fail, dilate the sphincter with thumbs or speculum.—*Potain.*

In acute cases, give hamamelis internally. From the first day the engorgement is lessened, the pain disappears, and the hemorrhoids shrink. When resolution has been obtained, continue the drug for a month.—*Dujardin-Beaumetz.*

℞.—Ung. Populii. . . . . ℥i.
Cerat. plunbi, ... ℥ijss.
Antipyrin, ... gr. xlv.
Ext. belladonnæ, ...
Ext. opii, ... aa gr. xv.

Misce bene.—S. Anoint the hemorrhoidal tumors if painful but not discharging, or after the hemorrhage has ceased. Daily enemas, to prevent constipation.—*Andhoni.*

EXTERNAL HEMORRHOIDS.—Anæsthetize the skin and mucous membrane with cocaine, applied on cotton. Pass a finger into the rectum, and inject six times, half a syringeful of cocaine solution, 2 per cent., between the mucosa and the cellular tissue around the rectum, avoiding the veins. When complete anesthesia has been produced, introduce a speculum and dilate the sphincter.—*Reclus.*

HOW TO DILATE THE SPHINCTER ANI.—Anesthetize the patient with nitrous oxide or bromic ether. Introduce the thumbs and dilate firmly, to the full extent. Go round the anal margin, repeating the dilatation until every part of the sphincter has been completely dilated

and paralyzed. This is to be done in cases where the sphincter is hypertrophic and in a spasmodic state of contraction, perhaps tightly constringing a protruding hemorrhoid.

PRURITUS ANI.

℞.—Hydrargyri chloridi corros., gr. ij.
Acidi hydrochlorici, . . . gtt., x.
Aquæ, ... ℥viij.
M. S. Apply locally, lukewarm
—*Laplace.*

℞.—Argenti nitratis, ... gr. xx.
Aquæ, ... ℥j.
M. S. Paint over itching surface.
—*Bartholow.*

℞.—Cocain. hydrochlorat, . . . gr. v,
Lanolini, ... ℥j.
M. S. Apply locally, after washing with warm water.
—*Besnier.*

℞.—Acidi carbolici, ... gr. vj.
Aquæ, ... ℥j.
M. S. Apply thrice daily.—*Heath.*

℞.—Benzoini, pulv. finiss., ... ℥j.
Hydrargyri ammonial. . . . ℥ss.
Lanolini, ... ℥j.
M. S. Apply twice daily. Avoid coffee, malt liquors, sugar and excess in meat.—*Waugh.*

BUREAU OF INFORMATION.

Questions on all subjects relating to medicine will be received, assigned to the member of our staff best capable of advising in each case, and answered by return mail.

When desired, the letters will be printed in the next issue of the Journal, and advice from our readers requested. The privileges of this Bureau are necessarily limited to our subscribers. Address all queries to

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